

Changing
THE
MINDSET



Early and Safe Return-to-Work



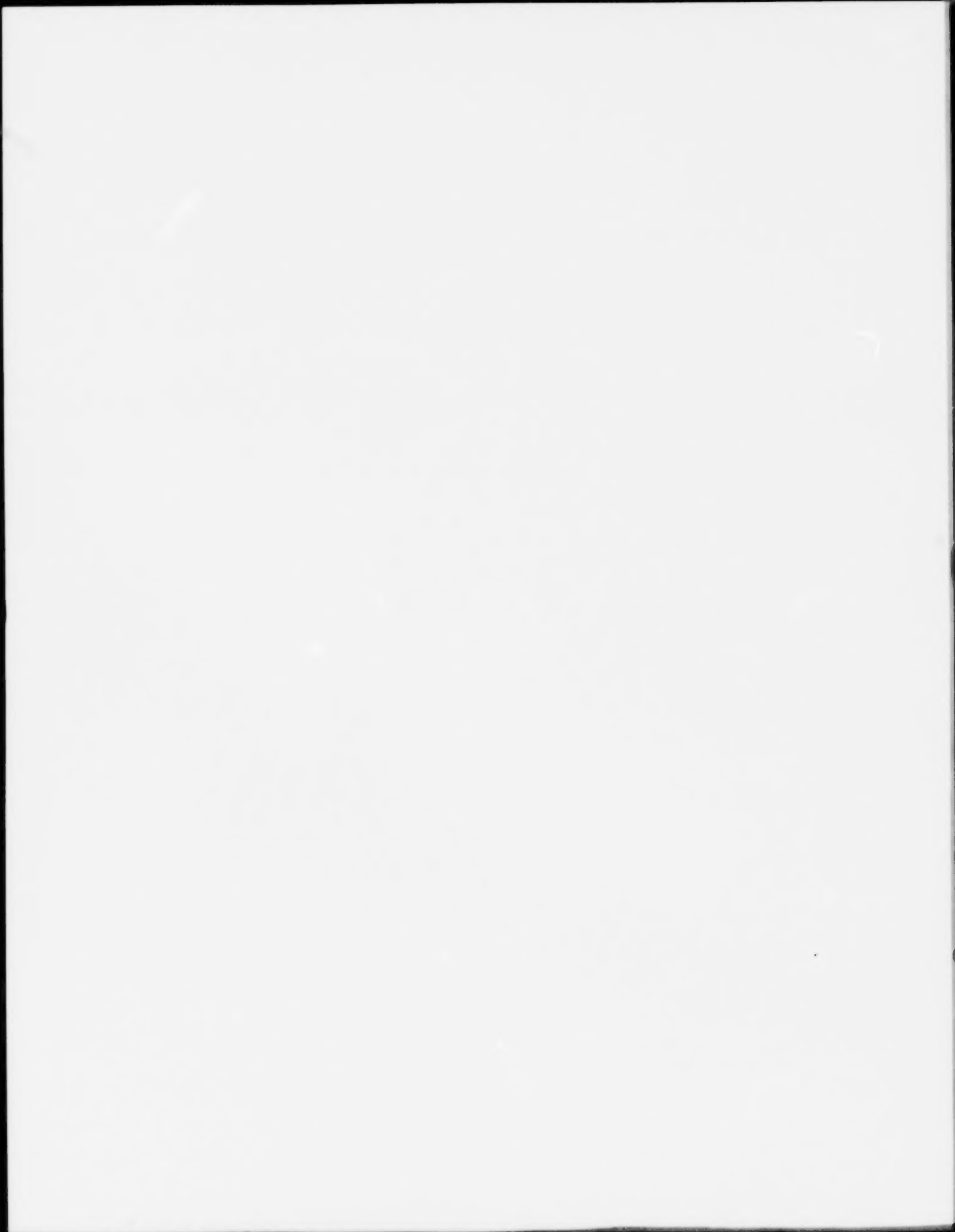


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INTRODUCTION

Preventing injuries is the responsibility of everyone at the workplace. Unfortunately, in spite of everyone's best efforts, workplace injuries and illnesses still occur. When this happens, it is important for the workplace parties (employers and workers) to focus on returning the injured worker back to a safe and productive work environment as soon as medically possible.

This booklet will:

- outline the legislative requirements for early and safe return-to-work in Newfoundland and Labrador; and
- show the benefits of return-to-work.

Important

A strong commitment is needed on everyone's part to achieve the goal of timely and safe return-to-work for all workers. A successful return-to-work plan requires the full involvement and co-operation of all parties, including:

- injured workers;
- employers and their supervisors;
- worker representatives/local union officials;
- health care providers;
- joint health and safety committees and worker representatives; and
- the Workplace Health, Safety and Compensation Commission (the Commission).

Construction Industry Exemption

Different rules for early and safe return-to-work apply for construction workers within the construction industry. Construction workers in the construction industry are exempt for now, but regulations are being developed for application in 2002 or early 2003. The duty to co-operate and re-employment obligations *do apply* to the non-construction workers of construction employers.

REQUIREMENTS UNDER THE NEW RETURN-TO-WORK MODEL

In February, 2001, the Task Force on Workers' Compensation released its report "Changing the Mindset." As a result, the *Workplace Health, Safety and Compensation Act* was amended under Bill 16 on May 24, 2001 to introduce early and safe return-to-work and labour market re-entry for injured workers. This new model is effective January 1, 2002.

This booklet provides an overview of key requirements for early and safe return-to-work in relation to duty to co-operate and re-employment obligations under the new legislative framework.

DUTY TO CO-OPERATE IN RETURN-TO-WORK

Effective January 1, 2002, all employers and workers (the workplace parties) are obligated under section 89 of *the Act* to co-operate in the worker's early and safe return to suitable and available employment with the injury employer.

Employers are required to:

1. Contact the worker as soon as possible after the injury occurs and maintain communication throughout the period of the worker's recovery or disability.
2. Provide suitable and available employment.
3. Give the Commission any information requested concerning the worker's return-to-work.

1. Effective communication: The frequency, method and content of communication between the workplace parties during the early and safe return-to-work process must be clearly understood and documented in the procedures outlined in the return-to-work program of the individual employer. The effectiveness of the communication process established in the workplace will largely depend on the commitment of the workplace parties. The Commission recommends, at a minimum, that an employer representative make contact with the worker at least once a week during the early and safe return-to-work process.

2. Provide suitable and available employment: The employer is required to provide suitable and available employment for the injured worker within three working days from receipt of the worker's functional ability information. Suitable employment should commence as soon as possible but no more than three working days after the employer has offered the work.

3. Information concerning the worker's return-to-work: Employers are required to provide the Commission with a written return-to-work plan which outlines an ongoing, progressive, early and safe return-to-work plan within one week of receiving the worker's functional ability information. The appendix of this booklet contains a copy of the early and safe return-to-work plan that must be submitted to the Commission. Employers must also provide written notification to the Commission of any changes in the early and safe return-to-work plan within one week of the change.

If a dispute arises in the return-to-work process between the worker and employer that cannot be resolved by the parties and could negatively impact return-to-work, the employer must contact the Commission immediately to advise of the dispute.

While early and safe return-to-work is the responsibility of the workplace parties, the Commission is available to provide advice and support, communicate with the workplace parties, monitor activities and progress, address compliance issues, and offer dispute resolution.

The best way for an employer to meet the co-operation requirements of the Act is to establish an effective return-to-work program.

SUITABLE EMPLOYMENT

In determining whether employment is suitable for an injured worker, consideration must be given to whether:

1. The work is within the worker's functional abilities.
2. The worker has, or is reasonably able to acquire, the necessary skills to perform the work.
3. The work does not pose a health or safety risk to the worker or co-workers.
4. The work restores the worker's pre-injury earnings, if possible.

Each of these concepts will be outlined further in the following pages.

1. Within worker's functional abilities

In determining whether the employment available is within the worker's functional abilities, the work capabilities outlined by the health care provider will be the main source of functional information. The worker is responsible for providing the employer's copy of the form 8/10, Physician's Report, from the health care provider, to the employer.

Any proposed employment should include the job duties to be performed, the physical requirements of those duties, the length of time spent in each duty, accommodations and/or modifications, if any, offered to offset functional restrictions, the total number of hours per day and the gross hourly salary

earned performing the work. If, as part of the employer's return-to-work program, an analysis of physical requirements has been completed on the employment being offered, then that information can also be used in determining if the work is suitable for a particular injured worker.

The workplace parties then compare the employment offered to the worker's functional abilities. Additional resources/evaluations may be used at this stage if the workplace parties cannot make this determination with the information available at the time. If the Commission agrees that a more comprehensive evaluation of the worker's functional abilities is required during the worker's early and safe return-to-work, the Commission can arrange and pay for the evaluation.

If the worker is physically capable of performing the employment offered, then the other elements of the suitable employment must be evaluated.

2. Worker's skills

The duty to co-operate does not require extensive retraining or skill development in order for the injured worker to participate. In considering whether the worker can reasonably acquire the skills, the timeliness of the early and safe return-to-work process must be a critical factor.

In most cases, the employer should be aware of its employees' skills, attributes and abilities. If not, the employer and worker must discuss these in relation to the employment being offered. Where an employee needs new skills, the reasonableness of acquiring these skills will be determined considering the following factors:

- the worker can attain the skills within a one-week period;
- the worker can attain the skills at the workplace or through a local training provider. (Local is defined as being within 25 kilometers (one way) of the pre-injury workplace or comparable worksite being proposed);
- the cost to the employer to train the worker is affordable; and
- the injured worker has the physical functional capacity and cognitive capacity to participate in the training and in the proposed return-to-work program.

3. Health and safety

The Newfoundland and Labrador Occupational Health and Safety Act outlines the legislative requirements of employers and workers to ensure a safe and healthy workplace. The employer is responsible for ensuring that the cause of a workplace injury has been rectified. As well, any offer of suitable employment must be safe for the injured worker and his/her co-workers.

4. Restores pre-injury earnings (if possible)

The employer is responsible for paying the salary earned by the worker during the early and safe return-to-work process. These earnings are taxable earnings and must be paid directly to the worker by the employer. The Commission will pay the worker the differential, if any, between the salary earned during the early and safe return-to-work process and 80% of net pre-injury earnings, to the maximum compensable earnings level.

It is in the long-term best financial interests of the employer to provide employment that, if possible, restores the worker's pre-injury earnings. Any wage loss paid by the Commission will be applied to the employer's injury experience which will contribute to the assessment base rate for the employer's rate group and to the employer's individual experience rating, where such a rate is applied.

When an employer chooses to pay an injured worker's wage-loss benefits (80% of net pre-injury earnings to the maximum compensable earnings of \$45,500 per year) directly to the worker and then recover the costs from the Commission, the claim is considered to be a "payable to employer" claim. For "payable to employer" situations, the employer submits the total actual remuneration paid and the total salary earned, by week, at the completion of the return-to-work initiative. The decision maker is responsible for calculating appropriate benefits for the worker and paying the employer the differential. While the worker will not be paid any wage-loss benefits directly by the Commission in such cases, the worker will be issued a T5007 from the Commission to reflect their wage-loss benefits paid directly by the employer. The employer is responsible for amending the worker's T4 to remove the benefits paid by the Commission.

Where the employer cannot pay the Commission portion as it is incurred, the employer must submit the return-to-work plan in advance and the Commission will pay appropriate benefits directly to the worker on a bi-weekly basis. Upon completion of the program, both the worker and employer must confirm the payments received by the worker from the employer.

AVAILABLE EMPLOYMENT

Work that exists

The duty to co-operate provisions of *the Act* do not require employers to create work where none exists. However, a job vacancy does not have to exist in order for available work to exist. The pre-injury position will always be the most suitable employment where the worker is physically capable of performing in the position. As a result, the worker's return to the pre-injury position should be explored before the position is filled by the employer.

Where an employer has multiple job sites, the suitable work may be available at a site comparable to the injured worker's pre-injury site. However, injured workers are not expected to travel unreasonable distances in order to avail of suitable employment.

RETURN-TO-WORK OPTIONS

Modified duties

Sometimes the most effective way to realize successful return to work is for the worker to never really leave work at all (or for as short a time as possible). Modified work may incorporate, but is not necessarily limited to, the worker's regular duties. The need for modified work is usually temporary, but it may be required on a permanent basis in some cases.

The duties, work and treatment schedule are planned and agreed to by the injured worker, employer and health care provider as appropriate. Generally, this approach to work injury allows normal life activities to continue while active medical treatment for the injury proceeds.

Easeback

This is an ideal method for employers, injured workers and their health care providers to deal with partial disability requiring a combination of rest and sensible activity. Easeback opportunities let injured workers return to their regular occupation gradually, while building up strength and tolerance in the process. Like modified work, a major benefit is that easebacks may be planned in conjunction with medical treatment.

The objective is to allow a steady progression of hours and/or duties with the end result being a return to full employment. Generally, programs will continue over a period of weeks, but they may last longer for a worker who has been significantly disabled. Each easeback is developed on its individual merit.

OBLIGATION TO RE-EMPLOY

The second component of the return-to-work model deals with re-employment obligations in accordance with the new section 89.1 of the Act. This obligation applies for injuries occurring on or after January 1, 2002.

The employer of a worker who is unable to work in his/her pre-injury job as a result of a workplace injury is required to offer to re-employ the worker within a maximum of two years from the date the worker loses time from work as a result of the injury, if:

1. The employer regularly employs 20 or more workers.

2. The worker was employed with the injury employer for a continuous period of one year immediately prior to the date of injury.
3. The worker is medically able to perform the essential duties of the pre-injury employment or to perform suitable work.

An employer is obligated to re-employ until the earliest of two years after the date of injury, one year after the worker is fit for the essential duties of the pre-injury job, or until the worker reaches age 65. The date of injury for re-employment purposes is the date the worker experiences loss of earnings capacity from the injury.

The employer's obligation to re-employ begins on the date that the worker is able to perform the essential duties of the pre-injury job or suitable employment.

When a worker is cleared for the essential duties of the pre-injury job, he/she will notify the employer and the Commission, and return to work. If the pre-injury job is not available, the employer must offer alternate comparable employment.

Where, following medical recovery from the injury, a worker is medically able to perform suitable work but is unable to perform the essential duties of the pre-injury job, the employer must offer the worker suitable employment that exists or becomes available throughout the period of the re-employment obligation period. Where the worker has returned to suitable work and subsequently becomes fit for essential duties within the re-employment obligation period, the employer must re-employ the worker in the pre-injury or comparable job.

The Commission has established procedures for determining whether a re-employment obligation exists for seasonal, casual, contractual, part-time and temporary workers. When an injury occurs, the employer and worker will be notified by the Commission if the employer has a re-employment obligation to the injured worker.

Employers also have an obligation to accommodate and re-employ injured and disabled workers under human rights legislation.

Report of re-employment

A report of re-employment will be used by the workplace parties whenever the worker returns to alternative comparable employment. It must indicate the following:

1. How the job is comparable in nature to the pre-injury job.
2. How the job is comparable in earnings to the pre-injury job.
3. The date the worker commences the job.

A return-to-work plan will be used by the workplace parties whenever the worker returns to suitable employment. It must indicate the following:

1. How the job will accommodate the worker's functional restrictions (this information is not required if the worker has been cleared for essential duties and the pre-injury job or a comparable job is not available).
2. The salary of the suitable job.
3. The date the worker commences the suitable job.

Employers are required to provide the Commission with written notification of any changes in the return-to-work plan within one week of their occurrence.

The Commission's role in early and safe return-to-work

The Commission is committed to providing guidance and support to employers who require assistance in establishing their early and safe return-to-work or re-employment programs. Depending on the individual needs and resources of the employer, the Commission's role may range from advising the employer where to access useful information on setting up effective disability management programs to actually becoming involved in the process (e.g., assisting to determine suitable employment). However, where possible, return-to-work solutions should be resolved by the workplace parties.

Mediation

Mediation is a workplace-centered conflict resolution process in which an impartial third party assists the participants to negotiate a consensual and informed resolution to the matter in dispute within the parameters of the return-to-work provisions of the *Workplace Health, Safety and Compensation Act*, Commission policies and procedures. In mediation, decision-making authority rests with the parties. The role of the mediator includes reducing the obstacles to communication, maximizing the exploration of alternatives, and addressing the needs of those it is agreed are involved or affected. Mediation is based on principles of problem solving that focus on the needs and interests of the participants, fairness, privacy, self-determination, and the best interest of all workplace parties.

PENALTIES

EMPLOYER PENALTIES

Employers who do not meet their co-operation and/or re-employment obligations will be subject to direct financial penalties.

Failure to co-operate

The Commission may levy a penalty not exceeding the cost of providing the worker's benefits, return-to-work and labour market re-entry services on employers who fail to co-operate in return-to-work. The penalty is applied from the start date of non-co-operation and is an amount owing to the Commission when it is levied and shall be added to the employer's assessment account.

Penalties levied against the employer for non-co-operation are for the period of non-co-operation and could include:

1. The worker's full wage-loss benefits paid by the Commission to the worker. This penalty will be levied against the employer's assessment account on a bi-weekly basis. For all wage-loss benefit penalties levied, an additional penalty amounting to 12.5% of wage-loss benefits will also be charged against the employer on a bi-weekly basis to cover the administrative cost to the Commission of providing the worker with benefits.
2. The full cost of the labour market re-entry assessment, if required, levied against the employer's assessment account when the assessment is completed.
3. The full cost of the labour market re-entry plan, if one is required, to help the worker become market ready, levied against the employer's assessment account on a quarterly basis as costs are incurred. These costs including, tuition, books, accommodations, travel, tools and equipment, etc., will be levied against the employer's assessment account.

These penalties will continue until the earliest date that:

- the employer co-operates; or
- the worker's entitlement to temporary earnings benefits ends.

Failure to re-employ

If the Commission determines that the employer has not fulfilled the re-employment obligation, it shall, in all but exceptional cases, levy on the employer a penalty not exceeding the amount of the worker's net average earnings for the 12 months immediately preceding the beginning of the loss of earnings as a result of the injury (i.e. net average earnings).

This amount is not subject to the maximum compensable earnings amount.

The penalty is applied from the start date of the re-employment obligation and is an amount owing to the Commission when it is levied and shall be added to the employer's assessment.

Example

The Commission determines that an employer has failed to re-employ a worker whose net average earnings are \$52,000 per year. Although these earnings are greater than the maximum compensable earnings, the penalty levied on the employer will be \$52,000.

Violating confidentiality

Employers and their representatives are prohibited by *the Act* from disclosing a worker's functional abilities information except to a person assisting the employer in returning the injured worker back to work. If prosecuted and convicted of this offense, violators are liable for a fine of up to \$25,000 or up to six months in jail, or both.

WORKER PENALTIES

Where the worker fails to demonstrate co-operation to the satisfaction of the Commission and does not have a legitimate reason for not co-operating, the worker's benefits shall be reduced, suspended or terminated, as determined appropriate by the Commission.

APPENDIX

Sample Commission Forms



www.whscc.nf.ca

Jan. 2002

THIS NUMBER WILL BE ASSIGNED
BY WHISCC WHEN THE FIRST
REPORT OF INJURY IS RECEIVED. IT
SHOULD THEN BE QUOTED ON ALL
CORRESPONDENCE.

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ALL WORKERS MUST CO-OPERATE IN EARLY AND SAFE RETURN-TO-WORK

THIS FORM SHOULD BE FILED WITHIN 3 DAYS OF THE INJURY

PART 1 - TO BE COMPLETED IN ALL CASES INVOLVING WAGE LOSS AND/OR VISIT TO A PHYSICIAN/CHIROPRACTOR

WORKER'S SURNAME				GIVEN NAMES			
WORKER'S ADDRESS						MCP NUMBER	
CITY OR TOWN						PROV	POSTAL CODE
DATE OF BIRTH	YEAR	MONTH	DAY	GENDER M F	SOCIAL INSURANCE NUMBER		TELEPHONE NO
EMPLOYER'S NAME							
EMPLOYER'S ADDRESS							
CITY OR TOWN						PROV	POSTAL CODE
FIRM NO				FAX NO		TELEPHONE	

1. Date and time of injury.
Year _____ Month _____ Day _____ Hour _____ am
Date and time injury reported to employer.
Year _____ Month _____ Day _____ Hour _____ am
Date and time of first medical visit
Year _____ Month _____ Day _____ Hour _____ am
2. Give the first day you missed work after the injury.
Year _____ Month _____ Day _____
3. To whom was the report made?
Name: _____
Title: _____
4. How many workers does your employer regularly employ?
(see re-employment obligation below.)
less than 20 _____ 20 or more _____

5. How long have you worked for your employer? years _____ or other (specify) _____
- Are you? full-time _____ part-time _____ seasonal _____ casual _____ 6. Compensation _____
7. Are you an owner or partner of the business? Yes _____ No _____
8. Did you notify your Occupational Health & Safety Committee or Workplace Health & Safety Representative of this injury? Yes _____ No _____
9. Did injury occur on employer's premises? Yes _____ No _____ State the injury worksite location and address. _____
10. Was the work being done for the purpose of the employer's business? Yes _____ No _____
11. How did this injury occur? Indicate the size, weight and description of the object, tool, machine, substance or equipment which was being handled or involved. _____
12. Describe the injury, mentioning the part of the body and if applicable, whether right or left side. _____
13. Give the names and addresses of witnesses (if any).
1. _____
2. _____
14. Give name of attending doctor: _____
and clinic/hospital _____
- WORKER MUST SIGN BELOW**

I authorize the Commission to obtain any

Please answer the following questions in as much detail as possible (attach separate sheet if necessary).

15. Describe what you were doing when you felt pain. _____
16. Was the pain felt immediately? Yes _____ No _____
Did you fall? Yes _____ No _____ If Yes, from what height? _____
17. Did you experience pain elsewhere? Yes _____ No _____ If Yes, describe. _____
18. Did you have any unusual feelings, i.e. numbness, tingling, weakness? Yes _____ No _____
If Yes, describe. _____
19. Did you stop working immediately? Yes _____ No _____ If No, when did you stop? _____
20. Have you returned to work? Yes _____ No _____ If Yes, when? _____
If No, how much longer does your doctor expect you to be off? _____

WORKER MUST SIGN BELOW

I authorize the Commission to obtain any information for the management of my claim and to share such information, including medical information, with external sources authorized by the Commission including, but not limited to, Human Resources Development Canada and Human Resources and Employment. I declare this form is complete and correct and understand that giving false information or omitting relevant information is a serious offense.

Signature _____

Date _____

PLEASE COMPLETE REVERSE. BOTH SIDES
OF DOCUMENT MUST BE SIGNED.

Please complete Part 2 in all cases involving lost-time greater than the day of the injury.

RE-EMPLOYMENT OBLIGATION

A re-employment obligation may exist if there are 20 or more workers with your employer and if you have been continuously employed for greater than one year. Contact your employer to determine if this re-employment obligation applies to you.

WHSCC USE ONLY

Name _____

Date of Injury _____
YEAR MONTH DAY**PART 2 - TO BE COMPLETED IN ALL CASES INVOLVING LOST-TIME GREATER THAN THE DAY OF INJURY**

1. If you worked since your injury please give dates.

Period Worked Since Injury	From	Year	Month	Day	To	Year	Month	Day	Total earnings for this period	\$	Has your employer paid you any other amounts during your disability?	Yes	
											No		

2. What were your gross earnings at the time of the injury? \$ _____ Indicate hourly, weekly, or specify, if other: _____

Show normal work week by entering hours worked each day.

Week 1	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Week 2	Sun	Mon	Tue	Wed	Thur	Fri	Sat

3. Is this your first claim with the Commission? Yes _____ No _____ If No, are you currently receiving any Commission benefits (including permanent disability pension)? Yes _____ No _____

4. Will you or are you receiving any benefits other than from the Commission? Yes _____ No _____

If Yes, please specify if it is salary or other benefits from an employer: _____

If Yes, please specify if it is Employment Insurance, Post-TAGS benefits, etc. Explain: _____

5. Have you asked your employer about returning to modified/light duties during your recovery? Yes _____ No _____

Has your employer offered you alternate/modified duties? Yes _____ No _____ If Yes, are you currently participating in these duties? Yes _____ No _____

6. Please choose the ones that best describe your status for income tax purposes:

- ☐ Married and claiming no exemption for spouse (spouse working)
☐ Married and claiming full exemption for spouse or equivalent
☐ Claiming for a disabled dependent relative
☐ Other _____

7. Do you want to authorize your spouse, other family member, a union representative, lawyer or MHA to access information on your claim? Yes _____ No _____ If Yes, please name the individual: _____

(You may change this person anytime by completing a WHSCC Form 13.)

PART 3 - PREVIOUS PROBLEMS

Have you had problems of this nature before? Yes _____ No _____ If Yes, please explain in the _____ at below

Previous Problems	Year	Part of Body	Indicate Left or Right	WHSCC Claim		Saw Specialist	MRI Scan	Tests			Surgery		Comments (attach additional paper if necessary)
				Yes	No			X-Ray	Other	Yes	No		
1st Problem													
2nd Problem													
3rd Problem													
4th Problem													

PART 4 - TO BE COMPLETED BY WORKERS ON FISHING VESSELS

1. Vessel Name / Type / Length _____

2. Personal Commercial Fishing Licence Year _____ Number _____ Date of Issue _____

3. Master's Name _____ Phone _____

Address _____ City/Town _____ Prov. _____ Postal Code _____

4. Are your earnings based on a share of the catch? Yes _____ No _____ If so, describe the share arrangement: _____

5. What overall expenses (i.e. gas, clothing, equipment, food, etc.) do you share and claim? _____

6. Show vessel's sales for the four weeks prior to date of injury.

Fish Buyer's Name, Address & Phone Number	Gross Sales	Periods Fished

Signature _____

Date _____



Workplace Health, Safety and Compensation Commission
146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8
Telephone: (709) 778-1000 Fax: (709) 778-1302
www.whscc.nf.ca

Jan. 2002

Please FAX or MAIL to

EMPLOYER'S REPORT OF INJURY

ALL EMPLOYERS MUST CO-OPERATE IN EARLY AND SAFE RETURN-TO-WORK

CLAIM NUMBER THIS NUMBER WILL BE ASSIGNED BY WHSCC WHEN THE FIRST REPORT OF INJURY IS RECEIVED. IT SHOULD THEN BE QUOTED ON ALL CORRESPONDENCE.	FORM 7
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THE EMPLOYER MUST FILE THIS FORM WITHIN 3 DAYS OF THE INJURY (Late and incomplete reports may result in a \$200 fine for a lost-time claim or \$100 for a medical aid only claim.)

PART 1 - TO BE COMPLETED IN ALL CASES INVOLVING WAGE LOSS AND/OR VISIT TO A PHYSICIAN/CHIROPRACTOR

WORKER'S - SURNAME		GIVEN NAMES	
WORKER'S ADDRESS			
CITY OR TOWN		PROV.	POSTAL CODE
DATE OF BIRTH	YEAR	MONTH	DAY
		GENDER	SOCIAL INSURANCE NUMBER
		M F	TELEPHONE NO.
EMPLOYER'S NAME			
☐ INCORPORATED ☐ LIMITED ☐ PARTNER ☐ PROPRIETOR ☐ OPTIONAL PERSONAL COVERAGE (If the business is not incorporated or limited, only partner/proprietor who has optional personal coverage is eligible for compensation.)			
EMPLOYER'S ADDRESS			
CITY OR TOWN		PROV.	POSTAL CODE
FIRM NO.	FAX NO.	TELEPHONE	

1. Date and time of injury.
Year _____ Month _____ Day _____ Hour _____ am/pm
2. Date and time injury reported to employer.
Year _____ Month _____ Day _____ Hour _____ am/pm
3. To whom was the report made?
Name: _____
Title: _____
4. How many workers do you regularly employ? _____
(see re-employment obligation below.)
Do you have seasonal, casual or contractual workers?
Yes _____ No _____
5. How long has this worker been in your employ?
Years _____ or other (specify) _____
Is this worker:
Full-time _____ part-time _____ seasonal _____ casual _____

6. Occupation: _____
State the injury worksite location and address: _____
7. Did injury occur on employer's premises? Yes _____ No _____
8. Was the work being done for the purpose of the employer's business? Yes _____ No _____
9. Has the Occupational Health and Safety Committee or Worker Health and Safety Committee been notified of this injury? Yes _____ No _____
10. Will the injury be investigated? Yes _____ No _____
Has this kind of injury happened before? Yes _____ No _____
12. How did this injury occur? Indicate the size, weight and description of any object, tool, machine, substance or equipment which was being handled or involved.

13. Describe the injury, mention the part of the body and if applicable, right or left side (attach incident report if available.)

14. Give the names and addresses of witnesses (if any).
1. _____
2. _____
15. Give name of attending doctor: _____
and clinic/hospital: _____
16. Was any person not in your employ involved in the injury?
(If Yes, please attach explanation on separate paper.) Yes _____ No _____
17. Do you know any reason why this claim should not be allowed?
(If Yes, please attach explanation on separate paper.) Yes _____ No _____
18. Has the worker lost-time at work beyond the day of injury?
(If Yes, please complete Part 2 on reverse side.) Yes _____ No _____
19. Has the worker been offered alternate/modified duties? Yes _____ No _____
If Yes, is the worker currently participating in these duties? Yes _____ No _____
If No, are alternate/modified duties available? Yes _____ No _____

EMPLOYERS MUST SIGN BELOW

I am a representative of the employer and I declare the form is complete and correct. I understand that giving false information or omitting relevant information is a serious offense.

Employer Representative (Please Print)

Employer Signature

Position

Telephone Number

Date (Y/M/D)

IF WORKER IS A FISHER COMPLETE PART 3.
PLEASE ATTACH ADDITIONAL COMMENTS
ON SEPARATE PAPER.

Please complete Part 2 in all cases involving lost-time greater than the day of the injury.

RE-EMPLOYMENT OBLIGATION

A re-employment obligation may exist if there are 20 or more workers in your employment and if you have continuously employed the injured worker for greater than one year.

CONSTRUCTION INDUSTRY ONLY: Except for non-construction workers, different rules apply for construction workers within the construction industry. Contact the Commission to determine if this exemption applies.

WHSCC USE ONLY

Worker's name _____ Date of injury _____
YEAR MONTH DAY

Jan 2002

FORM

7

PART 2 - TO BE COMPLETED IN ALL CASES INVOLVING LOST-TIME GREATER THAN THE DAY OF THE INJURY.
(The employer is responsible for wages on the day of the injury.)

19. Date and time worker stopped work: Year _____ Month _____ Day _____ Time _____ am
pm
20. If the worker returned to work for any period since the injury, please give dates:
Year _____ Month _____ Day _____ TO Year _____ Month _____ Day _____
21. Are you continuing to pay the worker directly during the lost-time period? Yes _____ No _____
(The employer cannot pay the worker an amount in excess of compensation entitlement.)
If Yes, please give details: _____
If No, give date worker stopped receiving wages: Year _____ Month _____ Day _____
22. If the worker is back to work, please give date of return: Year _____ Month _____ Day _____
23. Show separately for each week or pay period the worker's gross wages and lost-time for the four pay periods preceding injury (include bonuses, overtime, etc.).

Period From			To			Wages		Lost-Time		
Year	Month	Day	Year	Month	Day	\$	¢	HOLIDAYS WITHOUT PAY	SICKNESS WITHOUT PAY	LACK OF WORK
								DAYS	DAYS	DAYS
								DAYS	DAYS	DAYS
								DAYS	DAYS	DAYS
								DAYS	DAYS	DAYS

24. Please enter hours per day normally worked on this 14-day chart.

	Sun.	Mon.	Tue.	Wed	Thur.	Fri.	Sat.
Week 1							
Week 2							

PART 3 - THIS SECTION IS TO BE COMPLETED BY MASTER, OWNER OR PART OWNER. IF THE INJURED FISHER IS SELF-EMPLOYED IT IS ONLY NECESSARY TO COMPLETE THE WORKER'S REPORT OF INJURY - FORM 5.

1. Vessel Name / Type / Length _____
2. Personal Commercial Fishing Licence:
Year _____ Number _____ Date of Issue _____
3. Master's Name _____ Phone _____
Address _____ City/Town _____ Prov. _____ Postal Code _____
4. Are you owner, part owner or master of the vessel? Yes _____ No _____
5. How many crew members are on the vessel? _____
6. Are earnings based on a share of the catch? Yes _____ No _____ If so, describe the share arrangement. _____

7. Show vessel's sales for the four weeks prior to date of injury.

Fish Buyer's Name, Address & Phone Number	Gross Sales	Periods Fished

Employer Representative Signature

NOTE: The Occupational Health and Safety Act requires that all incidents resulting in serious injury be reported to the Occupational Health and Safety Branch at (709) 729-4444.

FOR ADDITIONAL FORMS CALL 778-1248 OR 778-1000 OR 1-800-563-9000



Workplace Health, Safety and Compensation Commission
146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8
Telephone: (709) 778-1000 Fax: (709) 778-1302
www.whscc.nf.ca

Jan. 2002

CLAIM NUMBER FORM
6R

Please FAX or MAIL to _____

WORKER'S QUESTIONNAIRE - RECURRENCE OF INJURY

ALL WORKERS MUST CO-OPERATE IN EARLY AND SAFE RETURN-TO-WORK

THIS FORM SHOULD BE FILED WITHIN 3 DAYS OF RECURRENCE OF THE INJURY.

PREVIOUS CLAIM NUMBER													
WORKER'S - SURNAME					GIVEN NAMES								
WORKER'S ADDRESS													
CITY OR TOWN					PROV.		POSTAL CODE						
DATE OF BIRTH	YEAR	MONTH	DAY	GENDER	SOCIAL INSURANCE NUMBER			TELEPHONE NO.					
				M F									
EMPLOYER'S NAME (current employer)					EMPLOYER'S NAME (pre-injury employer)								
EMPLOYER'S ADDRESS					EMPLOYER'S ADDRESS								
CITY OR TOWN			PROV.		POSTAL CODE		CITY OR TOWN			PROV.		POSTAL CODE	
TELEPHONE				FAX NO.		TELEPHONE				FAX NO.			

1. Date of initial injury _____
Year _____ Month _____ Day _____
2. Part of the body injured. _____
3. When did you first begin to experience recurrent problems?
Year _____ Month _____ Day _____
4. How many workers does your employer regularly employ?
(see re-employment obligation below.)
less than 20 _____ 20 or more _____
5. How long have you worked for your current employer?
years _____ other (specify) _____
Are you?
full-time _____ part-time _____ seasonal _____ casual _____
6. Occupation: _____
7. Provide the name(s) of any treating doctor(s)
(medical or chiropractic).

8. Please explain in detail what caused your recurrence. _____

9. Was there a new incident? Yes _____ No _____ When did it occur? _____ Where did it occur? _____

10. What is your current condition and what medical treatment are you receiving? _____

11. Did you experience medical problems related to your initial work injury from the time you were closed to the time of the recurrence? _____

12. What non-work related activities (sports, hobbies, accidents) have you participated in or experienced since the initial injury that could have contributed to or aggravated the recurrent problems? _____

13. Did you return to work after your claim for your initial work injury closed? Yes _____ No _____ If Yes, specify periods worked:
From: Year _____ Month _____ Day _____ To: Year _____ Month _____ Day _____
From: Year _____ Month _____ Day _____ To: Year _____ Month _____ Day _____

14. Did you lose any time from work because of this recurrence? Yes _____ No _____ If Yes, please provide date(s):
From: Year _____ Month _____ Day _____ To: Year _____ Month _____ Day _____
From: Year _____ Month _____ Day _____ To: Year _____ Month _____ Day _____

15. What is your current tax exemption classification?
☐ Married and claiming no exemption for spouse (spouse working).
☐ Married and claiming full exemption for spouse (spouse not working).
☐ Married and claiming partial exemption for spouse, state amount claimed.
☐ Other dependent exemptions, explain.

16. Are you receiving Canada Pension Plan Disability Benefits? Yes _____ No _____

17. Are you receiving Employer-Sponsored Pension Plan Benefits? Yes _____ No _____

18. Do you want to authorize your spouse, other family member, a union representative, lawyer or MHA to access information on your claim? Yes _____ No _____ If Yes, please name the individual: _____
(You may change this person anytime by completing a WHSCC Form 13.)

WORKER MUST SIGN BELOW

I authorize the Commission to obtain any information for the management of my claim and to share such information, including medical information, with external sources authorized by the Commission including, but not limited to, Human Resources Development Canada and Human Resources and Employment. I declare this form is complete and correct and understand that giving false information or omitting relevant information is a serious offense.

Signature _____

Date _____

PLEASE COMPLETE REVERSE. BOTH SIDES OF DOCUMENT MUST BE SIGNED

RE-EMPLOYMENT OBLIGATION

Unless your current employer is not the pre-injury employer, a re-employment obligation may exist if there are 20 or more workers with your employer and if you have been continuously employed for greater than one year. Contact your employer to determine if this re-employment obligation applies to you.

WHSCC USE ONLY

Jan. 2002

**FORM
6R**

Name _____

Date of injury _____
YEAR MONTH DAYDate of recurrence _____
YEAR MONTH DAY**LIST BELOW ANY PROBLEMS SINCE RETURN TO WORK AND RECURRENCE DATE**

Please complete the chart below giving details of any previous problems related to the part of body injured.

Previous Problems	Year	Part of Body	Indicate Left or Right	WHSCC Claim		Saw Specialist		Tests				Surgery		Comments (attach additional paper if necessary)
				Yes	No	Yes	No	CT Scan	MRI	X-Ray	Other	Yes	No	
1st Problem														
2nd Problem														
3rd Problem														
4th Problem														

TO BE COMPLETED BY WORKERS ON FISHING VESSELS

- Vessel Name / Type / Length _____
- Personal Commercial Fishing Licence Year _____ Number _____ Date of Issuance _____
- Master's Name _____ Phone _____
Address _____ City/Town _____ Postal Code _____
- Are your earnings based on a share of the catch? Yes _____ No _____ If so, describe the share arrangement. _____
- What overall expenses (i.e. gas, clothing, equipment, food, etc.) do you share a claim? _____
- Show vessel's sales for the four weeks prior to date of injury.

Fish Buyer's Name, Address & Phone Number	Gross Sales	Periods Fished

ADDITIONAL COMMENTS

Signature _____

Date _____



Workplace Health, Safety and Compensation Commission
146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8
Telephone: (709) 778-1000 Fax: (709) 778-1302
www.whscc.nf.ca

Jan. 2002

CLAIM NUMBER

FORM
7R

Please FAX or MAIL to

EMPLOYER'S QUESTIONNAIRE - RECURRENCE OF INJURY

ALL EMPLOYERS MUST CO-OPERATE IN EARLY AND SAFE RETURN-TO-WORK

THE EMPLOYER MUST FILE THIS FORM WITHIN 3 DAYS OF THE INJURY (Late and incomplete reports may result in a \$200 fine for a lost-time claim or \$100 for a medical aid only claim.)

WORKER'S - SURNAME				GIVEN NAMES			
WORKER'S ADDRESS							
CITY OR TOWN				PROV		POSTAL CODE	
DATE OF BIRTH	YEAR	MONTH	DAY	GENDER	SOCIAL INSURANCE NUMBER		TELEPHONE NO
				M F			
EMPLOYER'S NAME							
☐ INCORPORATED ☐ LIMITED ☐ PARTNER ☐ PROPRIETOR ☐ OPTIONAL PERSONAL COVERAGE (If the business is not incorporated or limited, only partner/proprietor who has optional personal coverage is eligible for compensation.)							
EMPLOYER'S ADDRESS							
CITY OR TOWN				PROV		POSTAL CODE	
FIRM NO.		FAX NO		TELEPHONE			

1. Date of initial injury. YEAR MONTH DAY
2. Part of the body injured _____
3. On what date were you first informed of the recurrence of the injury?
YEAR MONTH DAY
4. How many workers do you regularly employ? _____
(see re-employment obligation below.)
Do you have seasonal, casual or contractual workers?
Yes _____ No _____
5. How long has this worker been in your employ?
Years _____ or other (specify) _____
Is this worker:
full-time _____ part-time _____ seasonal _____ casual _____
6. Occupation: _____
7. Did any specific incident cause this recurrence? Provide date (Y/M/D), time and explain fully. (Attach incident report if available.)

8. Is the worker losing any time from work because of the recurrence? Please provide dates. (Y/M/D) _____
Date worker began losing wages: YEAR MONTH DAY
9. Did the worker lose time from work because of these problems after returning to work on the initial injury? Provide specific dates. (Y/M/D) _____
10. Did the worker have any change in job duties since returning to work following the initial injury? _____
11. Was the worker having any problems performing work prior to the recurrence? Yes _____ No _____
If Yes, did worker complain to supervisors or co-workers of problems? Explain. _____

12. What non-work related activities was the worker involved in which could be a contributing factor?

13. Were alternate/modified duties made available in an effort to allow the worker to continue working since the recurrence?

If Yes, describe. _____
If No, are alternate/modified duties available at this time? _____
14. Are there any comments you wish to make regarding the worker's claim for recurrence? Yes _____ No _____
(If Yes, please complete additional comments on reverse side.)

EMPLOYERS MUST SIGN BELOW

I am a representative of the employer and I declare the form is complete and correct. I understand that giving false information or omitting relevant information is a serious offense.

Employer Representative (Please Print)

Employer Signature

Position

Telephone Number

Date (Y/M/D)

IF WORKER IS A FISHER OR FOR
ADDITIONAL COMMENTS SEE SIDE 2 OF
THIS FORM.

Please complete Part 2 in all cases involving lost-time greater than the day of the injury.

RE-EMPLOYMENT OBLIGATION

A re-employment obligation may exist if there are 20 or more workers in your employment and if you have continuously employed the injured worker for greater than one year. The re-employment obligation does not apply if you are not the pre-injury employer.

CONSTRUCTION INDUSTRY ONLY: Except for non-construction workers, different rules apply for construction workers within the construction industry. Contact the Commission to determine if this exemption applies.

WHSCC USE ONLY

Worker's name _____

Jan. 2002

**FORM
7R**

Date of injury _____ Date of recurrence _____
YEAR MONTH DAY YEAR MONTH DAY

14. Show separately for each week or pay period the worker's gross wages and lost-time for the four periods immediately preceding the recurrence (include bonus, overtime, etc.)

Period From			To			Wages		Lost-Time		
Year	Month	Day	Year	Month	Day	\$	c.	HOLIDAYS WITHOUT PAY	SICKNESS WITHOUT PAY	LACK OF WORK
								DAYS	DAYS	DAYS
								DAYS	DAYS	DAYS
								DAYS	DAYS	DAYS
								DAYS	DAYS	DAYS

15. Are you continuing to pay the worker during the lost-time period? Yes _____ No _____
(The employer cannot pay the worker an amount in excess of compensation entitlement.)

THIS SECTION IS TO BE COMPLETED BY MASTER, OWNER OR PART OWNER. IF THE INJURED FISHER IS SELF-EMPLOYED IT IS ONLY NECESSARY TO COMPLETE THE WORKER'S REPORT OF INJURY - FORM 6.

1. Vessel Name / Type / Length _____
2. Personal Commercial Fishing Licence Year _____ Number _____ Date of Issue _____
3. Master's Name _____ Phone _____
- Address _____
City/Town _____ Prov. _____ Postal Code _____
4. Are you owner, part owner or master of the vessel? Yes _____ No _____
5. How many crew members are on the vessel? _____
6. Are earnings based on a share of the catch? Yes _____ No _____ So, describe the share arrangement. _____
7. Show vessel's sales for the four weeks prior to date of injury.

Fish Buyer's Name, Address & Phone Number	Gross Sales	Periods Fished

ADDITIONAL COMMENTS

Employer Representative Signature _____

NOTE: The Occupational Health and Safety Act requires that all incidents resulting in serious injury be reported to the Occupational Health and Safety Branch at (709) 729-4444.

FOR ADDITIONAL FORMS CALL 778-1248 OR 778-1000 OR 1-800-563-9000



Workplace Health, Safety and Compensation Commission

146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8
Telephone: (709) 778-1000 Toll Free Fax: 1-866-553-5119
www.whscc.nf.ca

Jan. 2002

Please FAX or MAIL to _____

PHYSICIAN'S REPORT

VISIT & INITIAL REPORT ☐
VISIT & FOLLOW-UP REPORT ☐
VISIT ONLY - NO REPORT ☐

FORM
8/10

DEMOGRAPHIC & BILLING INFORMATION (always complete)

CLAIM NUMBER	MCP	PHYSICIAN'S NAME
WORKER'S - SURNAME	GIVEN NAME(S)	ADDRESS
WORKER'S - ADDRESS	PROV.	POSTAL CODE
CITY OR TOWN	PROV.	POSTAL CODE
TELEPHONE NUMBER	DATE OF BIRTH	YEAR MONTH DAY
EMPLOYER'S NAME	DATE OF INJURY	
OCCUPATION/TYPE OF WORK	DATE OF VISIT	
		MCP FEE CODE
		AMOUNT
		REPORTING FEE
		TOTAL

CLINICAL INFORMATION

☐

INITIAL ASSESSMENT

☐

PROGRESS REPORT

DESCRIBE INJURY HISTORY (1st visit only) or relevant changes since previous reports, **PERTINENT OBJECTIVE FINDINGS:**

RELEVANT PAST HISTORY:

DIAGNOSIS:

FURTHER INVESTIGATION (e.g.: radiology, specialist, surgery)

DATE(S):

Do you want WHSCC to arrange an appointment with (please attach a referral letter): ☐ Orthopedics ☐ Neurology ☐ Neurosurgery

TREATMENT PLAN (including, physiotherapy, chiropractor, etc.)

MEDICATION PRESCRIBED:

WORK CAPABILITY:

☐

Pre-injury work without job modification

☐

Easeback to pre-injury work

☐

Modified Work*

*Modified Work/Functional Limitations: Based on my clinical findings and patient's report, this patient is limited in the following activities:

☐ Use of upper extremities (explain)

☐ Lifting (explain)

☐ Bending, twisting, or kneeling (explain)

☐ Climbing stairs/ladders (explain)

☐ Standing (explain)

☐ Walking (explain)

☐ Sitting (explain)

☐ Other (explain)

Explanation:

Estimate duration of Functional Limitation (days/weeks)

Not capable of any work at this time: ☐ Explain:

Estimate time before worker will be able to return to work in any capacity:

☐ 1 week

☐ 2 weeks

☐ 3 weeks

☐ > 3 weeks

Other conditions/factors affecting recovery:

I certify that this is a complete and accurate report. The fees charged are in accordance with the WHSCC Medical Fee Schedule and I have received no prior payment. I have read the reporting responsibilities on the back.

Physician's Signature _____

Date: _____

WHSCC USE ONLY

WHITE - WHSCC

YELLOW - PHYSICIAN COPY

PINK - EMPLOYER (PATIENT TO RETURN TO EMPLOYER)

REPORTING RESPONSIBILITIES

The Form 8/10 must be complete and legible.

- The Physician's "Initial Assessment" Report – must be submitted to WHSCC the first time a physician attends a patient for a work related injury or illness.
- The Physician's "Progress Reports" – are submitted on the same Form 8/10 – please indicate Initial Assessment or Progress Report on form. Progress Reports should only be submitted when there is a significant change in the worker's condition, treatment or return-to-work plan.
"Complete" – means that all sections are answered, especially pertinent injury history, **objective clinical findings**, diagnosis, treatment plan, **work capability (see below)**, and any other conditions/factors which may be affecting recovery.
- "Legible" – means that the report can be read in its entirety without undue difficulty.
- Reports which are not complete and/or legible will be returned.

The physician must provide the employer's copy of the Form 8/10 to the injured worker who will then give it to their employer.

WORK CAPABILITY

PHYSICIAN MUST INDICATE WORKER EITHER:

- Fit for pre-injury work without job modifications; or
- Fit for modified work with functional limitations identified and explained and duration estimated; or
- Not capable of return to work at this time with an explanation, and estimation when worker can return to work in any capacity.

If the Work Capability section is not completed as above, this report will be considered incomplete and will be returned.

EXAMPLES OF FUNCTIONAL LIMITATIONS:

- Performing repetitive movement against resistance and/or gripping.
- Driving motorized equipment.
- Lifting greater than _____ lbs. (estimate)
- Doing overhead work.
- Reaching above shoulder height.
- Standing for longer than _____ minutes/hours (estimate).
- Working for longer than _____ minutes/hours (estimate).
- Sitting for longer than _____ minutes/hours (estimate).
- Working in certain environmental conditions or work areas (elaborate).

Workplace Health, Safety and Compensation Commission

Area	Regular Telephone	Toll Free Telephone	Toll Free Fax Number
St. John's	(709) 778-1000	1-800-563-9000	
Corner Brook	(709) 637-2700	1-800-563-2772	1-866-553-5119
Grand Falls-Windsor	(709) 489-1600	1-800-563-3448	

Please complete and fax or mail to: Workplace Health, Safety and Compensation Commission,
146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8

Fax: Toll Free 1-866-553-5119

NOTE: If you fax your Form 8/10, do not mail the original, keep it for your files.



Workplace Health, Safety and Compensation Commission

Jan. 2002

146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8

Telephone: (709) 778-1000

www.whscc.nf.ca

Please FAX or MAIL to

PHYSICIAN'S REPORT

VISIT & INITIAL REPORT
VISIT & FOLLOW-UP REPORT
VISIT ONLY - NO REPORT

FORM
8/10

DEMOGRAPHIC & BILLING INFORMATION (always complete)

CLAIM NUMBER	MCP	PHYSICIAN'S NAME	
WORKER'S - SURNAME	GIVEN NAME(S)	ADDRESS	
WORKER'S - ADDRESS		PROV.	POSTAL CODE
CITY OR TOWN	PROV.	POSTAL CODE	DR'S PHONE NO.
TELEPHONE NUMBER	DATE OF BIRTH	YEAR	MONTH
EMPLOYER'S NAME		DATE OF INJURY	
OCCUPATION/TYPE OF WORK		DATE OF VISIT	
		MCP FEE CODE	AMOUNT
		REPORTING FEE	
		TOTAL	

CLINICAL INFORMATION

☐

INITIAL ASSESSMENT

☐

PROGRESS REPORT

DIAGNOSIS:

FURTHER INVESTIGATION (e.g.: radiology, specialist, surgery)

DATE(S):

Do you want WHSCC to arrange an appointment? Please attach a referral letter.

☐

Orthopedics

☐

Neurology

☐

Neurosurgery

TREATMENT PLAN (including, physiotherapy, chiropractor, etc.):

WORK CAPABILITY:

☐

Pre-injury work without job modification

☐

Easeback to pre-injury work

☐

Modified Work*

*Modified Work/Functional Limitations: Based on my clinical findings and patient's report, this patient is limited in the following activities:

☐

Use of upper extremities (explain)

☐

Lifting (explain)

☐

Bending, twisting, or kneeling (explain)

☐

Climbing stairs/ladders (explain)

☐

Standing (explain)

☐

Walking (explain)

☐

Sitting (explain)

☐

Other (explain)

Explanation:

Estimate duration of Functional Limitation: (days/weeks)

Not capable of any work at this time:

☐

Explain:

Estimate time before worker will be able to return to work in any capacity:

☐

1 week

☐

2 weeks

☐

3 weeks

☐

> 3 weeks

I certify that this is a complete and accurate report. The fees charged are in accordance with the WHSCC Medical Fee Schedule and I have received no prior payment. I have read the reporting responsibilities on the back.

Physician's Signature:

Date:

WHSCC USE ONLY

WHITE - WHSCC

YELLOW - PHYSICIAN COPY

PINK - EMPLOYER (PATIENT TO RETURN TO EMPLOYER)

All employers and workers are obligated under the *Workplace Health, Safety and Compensation Act* to co-operate in the worker's early and safe return to suitable and available employment with the injury employer while the worker is receiving active medical rehabilitation for a work injury.

The workplace parties must co-operate and be self-reliant in returning the worker to suitable and available employment.

Worker co-operation:

- (i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
- (ii) assist the employer, as may be required or requested, to identify suitable and available employment;
- (iii) accept suitable employment when identified; and
- (iv) give the Commission any information requested concerning the return-to-work plan, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

- (i) contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
- (ii) provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe return-to-work process. The Commission will pay the differential, if any, between the salary earned during early and safe return-to-work plan and 80% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
- (iii) give the Commission any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

**For more information, contact
Workplace Health, Safety and Compensation Commission**

Area	Regular Telephone	Toll Free	Fax Numbers
St. John's	778-1000	1-800-563-9000	778-1302
Corner Brook	637-2700	1-800-563-2772	639-1018
Grand Falls-Windsor	489-1600	1-800-563-3448	489-1616



Workplace Health, Safety and Compensation Commission
146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8
Telephone: (709) 778-1000 Fax: (709) 778-1302
www.whscc.nf.ca

Please FAX or MAIL to _____

EARLY AND SAFE RETURN-TO-WORK PLAN

TO BE RETURNED TO THE COMMISSION WITHIN 1 WEEK FROM RECEIPT OF FUNCTIONAL ABILITY INFORMATION

REFERENCE EMPLOYER'S GUIDE FOR INSTRUCTIONS.

EMPLOYEE		EMPLOYER
CLAIM NUMBER	SOCIAL INSURANCE NUMBER	PRE-INJURY POSITION

☐ RETURN-TO-WORK NOT APPROPRIATE AT THIS TIME

EXPLAIN _____

PLANNED DATE TO REVIEW AGAIN

YEAR	MONTH	DAY

PLEASE FORWARD UPDATED RETURN-TO-WORK PLAN AT THAT TIME.

☐ RETURN-TO-WORK APPROPRIATE

Check one or more which accurately describes the worker's return-to-work.

- ☐ **modified** pre-injury duties (working at reduced or full hours)
☐ **easeback** to pre-injury duties (from reduced to full hours)
☐ **alternate duties** (different from the pre-injury employment)
☐ full-time ☐ part-time ☐ part-time increasing to full-time
☐ **trial period** (at essential or all pre-injury duties, full-time hours)

DUTIES OF EARLY AND SAFE RETURN-TO-WORK PLAN. _____

ARE WORKPLACE MODIFICATIONS NECESSARY? ☐ NO ☐ YES, please explain. _____

RETURN-TO-WORK SCHEDULE

WEEK(S)	FROM AND TO DATE	PROGRAM	INDICATE HOURS OF WORK PLANNED FOR EACH DAY							GROSS HOURLY WAGE TO BE PAID BY EMPLOYER DURING PROGRAM
			SUN	MON	TUES	WED	THUR	FRI	SAT	

DO YOU INTEND TO PAY WORKER FOR HOURS NOT WORKED? ☐ YES ☐ NO

EXPECTED RETURN-TO-WORK DATE FOLLOWING COMPLETION OF PROGRAM

YY MM DD

IDENTIFY ANY ISSUES WHICH MAY INTERFERE WITH THE SUCCESS OF THIS PLAN. _____

EMPLOYER REPRESENTATIVE _____

DATE

YY MM DD

EMPLOYEE (INJURED WORKER) _____

DATE

YY MM DD

WHSCC USE ONLY

All employers and workers are obligated under the *Workplace Health, Safety and Compensation Act* to co-operate in the worker's early and safe return to suitable and available employment with the injury employer while the worker is receiving active medical rehabilitation for a work injury.

The workplace parties must co-operate and be self-reliant in returning the worker to suitable and available employment.

Worker co-operation:

- (i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
- (ii) assist the employer, as may be required or requested, to identify suitable and available employment;
- (iii) accept suitable employment when identified; and
- (iv) give the Commission any information requested concerning the return-to-work plan, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

- (i) contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
- (ii) provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe return-to-work process. The Commission will pay the differential, if any, between the salary earned during early and safe return-to-work plan and 80% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
- (iii) give the Commission any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

In the case of non-co-operation, the Commission shall levy a penalty on the worker and/or employer.

Penalties

Worker - the worker's benefits shall be reduced, suspended or terminated, as determined appropriate by the Commission.

Employer - a penalty shall be levied.

DIRECTIONS FOR COMPLETION OF THE EARLY AND SAFE RETURN-TO-WORK (early safe return-to-work) PLAN

1. Who is responsible for developing the early safe return-to-work plan?

It is the responsibility of the employer to develop the early safe return-to-work plan. However, the case manager will provide assistance if necessary.

2. How does the employer know if the worker is capable of early safe return-to-work?

The worker's health care provider will provide work capability information during the first medical visit following the injury. The worker will return this to the employer. This form will contain brief descriptions of the worker's functional limitations as a result of the injury. The worker and employer will determine if the worker can return to work with these limitations.

3. What is the purpose of the early safe return-to-work plan?

This form is designed to capture and communicate necessary information for the Commission to determine that both the employer and worker are co-operating and taking responsibility in the early safe return-to-work process. It also provides the workplace parties with a clear understanding of the early safe return-to-work plan.

4. Can the early safe return-to-work program commence prior to the Commission receiving the early safe return-to-work plan?

Yes. The Commission supports that the early safe return-to-work program begin as soon as possible. Ideally, no later than three days following receipt of the functional ability information. The early safe return-to-work plan must be faxed to the Commission within one week of receipt of the functional ability information. The fax number is 778-1302.

5. What are suggestions for an early safe return-to-work program?

The type of program will depend on the results of the health care provider's work capability information and the functions of the workplace. The program could be full-time, part-time, or part-time with a progression towards full-time. The worker may perform some of the duties of the pre-injury employment or duties which are modified or alternate duties which are not normally part of the worker's pre-injury employment. Although the primary responsibility rests with the employer to identify an appropriate plan, we encourage the workplace parties to be creative when deciding upon an early safe return-to-work plan. The plan may contain several types of programs but the ultimate goal is a progressive move towards a worker's return to the pre-injury employment.

6. Who pays during the early safe return-to-work program?

The employer pays the worker for the hours of work and the value of the work performed during the early safe return-to-work program. The Commission will pay the difference, if any, between the salary earned during the early safe return-to-work program and 80% net of the worker's pre-injury earnings (wage loss benefit rate). If the salary earned during the early safe return-to-work program is less than the worker's pre-injury earnings, but higher than the wage loss benefit rate, there is no entitlement to wage loss benefits from the Commission as this is contrary to our legislation.

The gross salary earned per hour must be documented on the early safe return-to-work plan. Once received, the Commission will calculate any entitlement to wage-loss benefits and notify the workplace parties.

7. Will the Commission pay wage-loss benefits, if applicable, to the worker or the employer?

The Commission can do either, depending upon the request of the employer. Unless notified by the employer, the Commission will pay wage-loss benefits directly to the worker, if entitlement exists.

8. If the employer prefers a payable to employer arrangement versus payable to worker, how is this setup?

The employer must notify the Commission immediately of this request, for two reasons:

- 1) to prevent an overpayment to the worker; and
- 2) to confirm the wage-loss benefit rate - this will prevent the situation of the employer unintentionally paying the worker more than the wage loss benefit rate, resulting in a decision that the Commission will not be able to pay wage-loss benefits on the claim (see # 6).

The employer may choose to be reimbursed directly every two weeks, or at intervals during the early safe return-to-work program, or at the completion of the program for the difference between the salary earned during the early safe return-to-work program and 80% of the worker's net pre-injury earnings.

The employer must discuss the preferred arrangement with the case manager.

9. What should the employer do if there is a change to the early safe return-to-work plan?

The employer must complete another early safe return-to-work plan and fax to the Commission within one week of the effective date of this change. Minor variations within the plan do not need to be reported to the Commission. The Commission must be notified of any change which may affect the benefit rate.

10. Where does the employer get a copy of the early safe return-to-work plan?

A sample of the plan is enclosed with this package. You may make as many photocopies of this as you wish. A sample plan can also be downloaded from the Commission's web site (www.whscc.nf.ca). The Commission will also fax or mail a copy to you upon your request.

11. If the worker's injury prevents an early and safe return to work immediately following the injury, what should the employer do?

If the workplace parties agree and this decision is supported by the health care provider's work capability information, the "not capable of return to work" section of the early safe return-to-work plan should be completed and faxed to the Commission within one week of receipt of the functional ability information. Following this time, the workplace parties will continue to monitor the health care provider's work capability information with a view to starting early safe return-to-work as soon as possible. The Commission will expect an updated plan within one week of the date indicated by you that the early safe return-to-work will be reviewed again.

12. If a dispute arises between the workplace parties in the development of or during the early safe return-to-work plan, what should the employer do?

If attempts to resolve this dispute have been unsuccessful, the employer must contact the Commission immediately. The case manager will assist in resolving this dispute and/or mediation services will be offered.



Workplace Health, Safety and Compensation Commission
146-148 Forest Road, P.O. Box 9000, St. John's, NF A1A 3B8
Telephone: (709) 778-1000 Fax: (709) 778-1302
www.whscc.nf.ca

SAMPLE

Please FAX or MAIL to

EARLY AND SAFE RETURN-TO-WORK PLAN

TO BE RETURNED TO THE COMMISSION WITHIN 1 WEEK FROM RECEIPT OF FUNCTIONAL ABILITY INFORMATION

REFERENCE EMPLOYER'S GUIDE FOR INSTRUCTIONS.

EMPLOYEE <i>John Doe</i>	EMPLOYER <i>XYZ Inc.</i>
CLAIM NUMBER <i>123456</i>	SOCIAL INSURANCE NUMBER <i>123 456 789</i>
PRE-INJURY POSITION <i>Cashier</i>	

☐ RETURN-TO-WORK NOT APPROPRIATE AT THIS TIME

EXPLAIN _____

PLANNED DATE TO REVIEW AGAIN

YEAR	MONTH	DAY

PLEASE FORWARD UPDATED RETURN-TO-WORK PLAN AT THAT TIME

☒ RETURN-TO-WORK APPROPRIATE

Check one or more which accurately describes the worker's return-to-work.

- ☐ modified pre-injury duties (working at reduced or full hours)
☒ ease back to pre-injury duties (from reduced to full hours)
☐ alternate duties (different from the pre-injury employment)
☐ full-time ☐ part-time ☐ part-time increasing to full-time
☐ full period (at essential or all pre-injury duties, full-time hours)

DUTIES OF EARLY AND SAFE RETURN-TO-WORK PLAN *The employer is responsible for general cleanliness of store and customer service. Duties include serving ice cream and making sandwiches or waiting cash and stocking shelves.*

ARE WORKPLACE MODIFICATIONS NECESSARY? ☒ NO ☐ YES please explain _____

RETURN-TO-WORK SCHEDULE

WEEK(S)	FROM AND TO DATE	PROGRAM	INDICATE HOURS OF WORK PLANNED FOR EACH DAY							GROSS HOURLY WAGE TO BE PAID BY EMPLOYER DURING PROGRAM
			SUN	MON	TUES	WED	THUR	FRI	SAT	
1 & 2	Jan. 3-16	Easeback		4		4		4		\$5.60
3 & 4	Jan. 17-30	Easeback		4	4	4	4	4		\$5.60
5 & 6	Jan. 31-Feb. 13	Easeback		6	6	6	6	6		\$5.60

DO YOU INTEND TO PAY WORKER FOR HOURS NOT WORKED? ☐ YES ☒ NO

EXPECTED RETURN-TO-WORK DATE FOLLOWING COMPLETION OF PROGRAM *02 02 14*
YY MM DD

IDENTIFY ANY ISSUES WHICH MAY INTERFERE WITH THE SUCCESS OF THIS PLAN _____

EMPLOYER REPRESENTATIVE

John Smith

DATE

02 01 02
YY MM DD

WHSCC USE ONLY

EMPLOYEE (INJURED WORKER)

John Doe

DATE

02 01 02
YY MM DD

NOTE: See reverse for information regarding co-operation and penalties.

All employers and workers are obligated under the *Workplace Health, Safety and Compensation Act* to co-operate in the worker's early and safe return to suitable and available employment with the injury employer while the worker is receiving active medical rehabilitation for a work injury.

The workplace parties must co-operate and be self-reliant in returning the worker to suitable and available employment.

Worker co-operation:

- (i) contact the injury employer as soon as possible after the injury occurs and maintain effective communication throughout the period of recovery or impairment;
- (ii) assist the employer, as may be required or requested, to identify suitable and available employment;
- (iii) accept suitable employment when identified; and
- (iv) give the Commission any information requested concerning the return-to-work plan, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

Employer co-operation:

- (i) contact the worker as soon as possible after the injury occurs and maintain effective communication throughout the period of the worker's recovery or impairment;
- (ii) provide suitable and available employment. The employer is responsible to pay the worker's salary earned during the early and safe return-to-work process. The Commission will pay the differential, if any, between the salary earned during early and safe return-to-work plan and 80% of the worker's net pre-injury earnings subject to the maximum compensable ceiling; and
- (iii) give the Commission any information requested concerning the worker's return to work, including information about any disputes or disagreements which arise during the early and safe return-to-work process.

In the case of non-co-operation, the Commission shall levy a penalty on the worker and/or employer.

Penalties

Worker - the worker's benefits shall be reduced, suspended or terminated, as determined appropriate by the Commission.

Employer - a penalty shall be levied.

ADDITIONAL INFORMATION

For more information regarding early and safe return-to-work or the re-employment obligation, or to obtain copies of the Commission's policies, procedures and forms on this topic, please contact the Commission or visit our web site.

WORKPLACE HEALTH, SAFETY AND COMPENSATION COMMISSION

St. John's

146-148 Forest Road

P.O. Box 9000

St. John's, NF

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Telephone (709) 778-1000

Fax (709) 778-1110 (Assessment Services)

Fax (709) 778-1302 (Compensation Services)

Toll Free 1-800-563-9000

Grand Falls-Windsor

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P.O. Box 850

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Telephone (709) 489-1600

Fax (709) 489-1616

Toll Free 1-800-563-3448

Corner Brook

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